AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Committed to Excellence in Health Care

Jane Dee Hull
Governor

Phyllis Biedess
Director

October 1, 2002

Mr. Richard Stavneak, Director
Joint Legislative Budget Committee
1716 W. Adams
Phoenix, AZ 85007

Dear Mr. Stavneak:

In accordance with Laws 2002, Chapter 327 § 6, AHCCCS is submitting the requested Cost Sharing Report that identifies new or additional cost sharing measures that could be implemented. The Report primarily discusses strategies that have a chance of approval by the Centers for Medicare and Medicaid Services (CMS).

Medicaid law is very restrictive about the amount of cost sharing that can be imposed on the traditional Medicaid population. There is more flexibility on expansion populations such as the 100% of Federal Poverty Level groups, KidsCare children and the parents of KidsCare children. Any proposal will require federal approval, which could take four to six months, and authorizing state legislation. The strategies that the Cost Sharing Report identifies as possibilities are: new as well as increased copayments and monthly premiums, a monthly premium for households with children enrolled in the long term care program and an initial enrollment fee for eligibility groups who have higher income levels.

Although the Cost Sharing Report contains estimates of the amount of new revenue that could be generated, the figures are optimistic and require several qualifications. First, not all of the revenue will directly benefit the General Fund. For example, copayments are collected by providers, not the AHCCCS program, and the total amount is used to determine a potential offset to an increase in capitation rates. For the Traditional Medicaid population, copayments must be waived if the enrollee can not afford to pay which reduces the rate of collection to about 2% for this population. Second, fees may have a chilling effect on enrollment and may actually increase health care costs if people wait to enroll until they are seriously ill. Third, the estimates for the expansion population are based on CMS' approval of a waiver that gives the state the ability to mandate a copayment or deny services. Finally, AHCCCS does not have solid experience in estimating all of the ramifications of higher cost sharing amounts. The actual revenue that may be generated could be lower than the forecasts or there may be unintended consequences that increase the cost to the program if healthy people do not enroll until they are sick.

AHCCCS wants guidance from the Joint Legislative Budget Committee before proceeding with these cost sharing measures. If a decision is made to pursue any or all of these strategies, CMS will need at least four to six months to make a decision. Therefore, AHCCCS believes that October 1, 2003 is the earliest date to operationalize changes to cost sharing. It will take at least 12 months from implementation to determine if the forecasts are accurate and if the strategies can save money for the program.

If you have any questions, please contact Lynn Dunton at (602) 417-4447.

Sincerely,

Phyllis Biedess
Director

Enclosure

c Jennifer Vermeer, Assistant Director, JLBC